New Patient Registration Form

PATIENT IDENTIFICATION - Please Print

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	MIDDLE INITIAL

MAILING ADDRESS	CITY	STATE	ZIP CODE
STREET ADDRESS - if different from mailing address	CITY	STATE	ZIP CODE

HOME PHONE NUMBER ( )	COUNTY OF RESIDENCE	AGE	BIRTH DATE	SOCIAL SECURITY NUMBER
CELL PHONE NUMBER ( )	E-MAIL			

❑ MR. ❑ MRS. ❑ MISS ❑ MS. ❑ DR.

❑ MALE ❑ FEMALE	**MARITAL STATUS:** ❑ SINGLE ❑ DIVORCED ❑ MARRIED ❑ SEPARATED ❑ WIDOWED	**ETHNIC ORIGIN:** ❑ WHITE ❑ ASIAN OR PACIFIC ISLANDER ❑ HISPANIC ❑ AMERICAN INDIAN / ALASKAN ❑ BLACK ❑ UNKNOWN

PATIENT'S OCCUPATION	EMPLOYER'S NAME	EMPLOYER'S PHONE ( )	EXT.
EMPLOYER'S MAILING ADDRESS	CITY	STATE	ZIP

REFERRING DOCTOR	CITY	FAMILY DOCTOR	CITY

PERSON TO NOTIFY (NAME OF SOMEONE NOT LIVING WITH YOU)	PHONE ( )	RELATIONSHIP TO PATIENT

IS THIS INJURY ❑ OR ILLNESS ❑	WORK RELATED? ❑ YES ❑ NO	AUTO ACCIDENT RELATED? ❑ YES ❑ NO	OTHER ACCIDENT RELATED? ❑ YES ❑ NO	HOW DO YOU WISH TO PAY TODAY? ❑ CASH ❑ CHECK ❑ CHECK

At Commonwealth Eye Surgery, we are committed to treating and using protected health information about you responsibly. You may view our Notice of Health Information Practices on our website at www.commonwealtheyes.com or you will be offered a copy of this policy at the time of your first treatment. Signing below acknowledges you have reviewed this policy and find it acceptable.

Sign ______________________________

Print ______________________________

Date ______________________________

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INSURANCE - Please present ALL your insurance cards(s) to the receptionist so that we may determine whether or not we participate with your insurance plan.

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I consent to treatment necessary for the care of the above-named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmittal of all medical records, if necessary.
I authorize Commonwealth Eye Surgery to use photos or information concerning my case in the interest of medical education, and I understand that I will not be identified by name.
I acknowledge that I am responsible for payment at the time of each visit for all services rendered by Lance S. Ferguson, M.D., P.S.C., which are not covered by an assigned insurance or agency authorization or for which no prior payment arrangement has been made.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Patient's (or other authorized person's) Signature:______________________________ Date ______________

PLEASE SEE REVERSE FOR ASSIGNED INSURANCE AUTHORIZATIONS

1	1	1	1	2	2	2	2	3	3

ACCT. #